

treatment option which often requires proximal landing-zone extension through left subclavian artery (LSA) origin coverage. This can lead to downstream ischaemic complications which may be lessened by revascularisation. We investigate the consequence of LSA coverage and potential benefit of revascularisation.

Methods: Literature review between 1997–2010 identified 94 studies incorporating 1,704 patients. Primary outcomes were left-arm-ischaemia, stroke, spinal-cord-ischaemia, endoleak, stent-migration, additional procedure and mortality. These were compared in patients with and without LSA coverage and the impact of revascularisation was explored.

Results: Total LSA coverage without revascularisation increases the prevalence of left-arm-ischaemia [4.06%vs.0.0 %($p<0.001$)]; stroke [1.19%vs.0.23%($p=0.025$)]; and additional procedure [2.86%vs.0.86%($p=0.004$)]. There were no reported cases of stroke, spinal-cord-ischaemia, endoleak, stent-migration or mortality when the LSA origin was only partially covered. When the LSA territory was revascularised, again no cases of left-arm-ischaemia, stroke, spinal-cord-ischaemia, endoleak, or mortality were reported.

Conclusion: LSA coverage in patients undergoing endovascular stent-grafting of the thoracic aorta for trauma should be avoided where possible to avoid downstream ischaemic complications. When coverage is anatomically necessary, partial coverage is better than complete in terms of avoiding these complications and revascularisation may be considered.

0362 MANAGING PATIENT PATHWAYS TO ACHIEVE LUNG CANCER WAITING TIME TARGETS: A MIXED METHOD STUDY

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Background: The NHS introduced the 62-day target to make lung cancer pathways more efficient. This study aims to understand pathway delays which contribute to breaches of the target when patients require care in both secondary and tertiary settings, thus involving more than one institution.

Methods: This was a mixed method cross case analysis utilising qualitative methods (pathway mapping and semi-structured interviews) and quantitative analysis of patient pathway times from cancer services records. Setting: Two tertiary referral hospitals in London.

Participants: Database records of 53 patients were analysed. 19 sets of patient notes were used for pathway mapping. 17 doctors, 4 nurses, 8 managers and administrators were interviewed.

Results: The majority of the patient pathway (68.4%) is spent in secondary centres. There is more variability in the processes of secondary centres (Standard Deviation 11.9 days versus 9.9 days ($p<0.10$ F-test)) but tertiary centres do not have perfect processes either. Three themes emerged from the semi-structured interviews: information flows, pathway performance, and the role of the multidisciplinary approach.

Conclusions: The actions of secondary healthcare centres have a greater influence on whether a patient breaches the 62-day target, compared to tertiary centres. Nevertheless variability exists in both, with scope for improvement.

0363 HOW SUCCESSFUL ARE ENT SERVICES IN COMPLYING WITH NATIONAL TARGETS FOR SUSPECTED CANCERS AND NON-URGENT REFERRALS?

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Introduction: The NHS Cancer Plan 2000 sets out a two-week maximum wait for out-patient appointments for all suspected cancers. The NHS Improvement Plan 2004 has set an 18-week limit from referral to the start of treatment for non-cancer cases. To our knowledge systematic evaluation of adherence to these targets is lacking and we therefore undertook an audit to address this issue.

Method: A prospective audit was performed at a local GP practice over a four month period. EMIS database was used to retrieve correspondence with commissioned ENT services. The date of referral, clinic attendance, type of investigations, and date of first definitive treatment were observed. Standards for the two-week and 18 week target are both 100%.

Results: $n=31$ 97% (30/31) of cases were compliant with the 'two-week rule'. Only 42% (13/31) of cases were compliant with the 18-week pathway. Of the cases that breached the 18-week pathway, 56% (10/18) were pending clinic, 33% (6/18) investigations and 11% (2/18) treatment.

Conclusion: Despite extensive frameworks formulated by the Department of Health for tackling waiting times, our data suggests that the local ENT services are not in compliance with the two-week or 18-week standards. There is need for wider debate and national review.

0364 THE ADRENAL INCIDENTALOMA – HOW IS IT BEST FOLLOWED-UP?

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Introduction: This study analysed the follow-up of adrenal incidentalomas (AI's) based on guidelines suggested by Herrera¹.

Method: Between October 2008 and October 2009, 3824 abdominal computed tomography (CT) scans were performed at Blackpool Victoria Hospital. 123 AI's were detected.

Results: 82 AI's (66.7%) were not measured. 41 AI's (33.3%) were measured - 38 (92.7%) were between 1–4cm and 3 (7.3%) were >4cm. Of these 41 AI's measuring >1cm, only 20% had biochemical screening - 25% of which were abnormal. Only 34% of AI's >1cm had any form of follow-up. Out of 3 AI's measuring >4cm, one was excised.

Discussion: A high proportion of AI's in our study were not measured and described as 'bulky', leaving interpretation difficult. Approximately 80% of AI's are non-functioning or benign.² Many authors conclude repeated imaging is of little benefit due to radiation exposure and low incidence of developing malignancy^{3,4,5}. We recommend reporting should be more specific. At present, there are no national guidelines for the management and follow-up of AI's. This study highlights the need of such guidelines for the reporting, follow-up and management of AI's, being both cost-effective and safe to assist physicians in providing consistent follow up of AI's.

0366 IMPROVED PATIENT SAFETY USING COMPUTERISED HANDOVERS FOLLOWING EWTD IMPLEMENTATION

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Aim: Handover is an important part of surgical on call, especially as the introduction of EWTD has lead to more frequent changeovers during a typical shift. A previous audit at St Heliers Hospital resulted in implementation of computerised spreadsheets to hand over patients in a safe and effective manner. We completed the loop by re-auditing to assess current handovers.

Method: Handover spreadsheets were collected over an eight-day period at St Heliers hospital during August 2010 and accuracy of information was assessed. Inclusion of details such as patient number, date of birth, ward number, bed number, diagnosis, past medical history, blood results, scan results and plan implementation were recorded.

Results: 83 patients were seen during general surgery take. 94% had correct patient numbers, 94% had correct DOBs, 95% had correct ward, 34% had correct bed number, 99% had a diagnosis, 57% had past medical history, 81% had blood results, 70% had scan results and 93% had a written plan.

Conclusion: Re-audit has shown improved accuracy of handovers due to implementation of a computerised handover proforma. Suggestions made following the re-audit include education of junior doctors at induction and commencing a formal registered handover to reduce the risk of near misses.

0371 IS 'HOT CLINIC' A 'HOT' IDEA FOR EVALUATING EMERGENCY SURGICAL ADMISSIONS?

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Aims: To assess the impact of a dedicated 'hot clinic' within the setting of emergency surgical admissions unit on the delivery of emergency surgery